Internal Audit Report

MIHS Family Health Centers
July 2001

Avondale Family Health Center

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July 30, 2001

Janice K. Brewer, Chairman, Board of Supervisors
Fulton Brock, Supervisor, District I
Don Stapley, Supervisor, District II
Andrew Kunasek, Supervisor, District III
Mary Rose Wilcox, Supervisor, District V

We engaged Arthur Andersen, LLP, to perform a review of the Maricopa Integrated Health System (MIHS) Family Health Centers (FHC). This audit was conducted in accordance with the annual audit plan that was approved by the Board of Supervisors. The highlights of this report are:

- Testing showed that MIHS lost the ability to bill patients for $15,000 of "Medicare denied claims" because MIHS had not notified the patients of the potential billing liability via the appropriate forms.
- We found that only five of the twelve FHCs performed detailed reconciliations to ensure that all patient charges are recorded, reasonable, and supported by encounter documentation. This lack of charge reconciliation may result in lost, unbilled, or incorrectly billed charges.
- The Comprehensive Healthcare Center's Business Operations Director estimates unbilled services to be one million dollars. This lack of billing is due to potential misunderstandings of compliance and regulatory issues. According to the Director, the Billing Office is currently researching and submitting claims for reimbursement of these previously unbilled fees.

Attached are the report summary, detailed findings, recommendations, and the MIHS Director's response. Arthur Andersen, LLP, has reviewed this information with MIHS management. If you have questions, or wish to discuss this report, please contact Eve Murillo at 506-7245.

Sincerely,

Ross L. Tate

Ross L. Tate
County Auditor

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Executive Summary

Advance Beneficiary Notices

Maricopa Integrated Health Systems (MIHS) Family Health Centers (FHC) lose the ability to bill patients for services not covered by Medicare when the FHCs do not advise patients, through Advance Beneficiary Notices (ABNs), that Medicare may not pay for specified services. Andersen sampled 79 of 187 Medicare denials for a recent nine-month period and determined that 100% of the sample did not have ABNs on file. This finding represents approximately $15,000 in denied Medicare claims that MIHS cannot bill to patients. MIHS should ensure that ABNs are provided to Medicare beneficiaries when appropriate.

Charge Reconciliation

A charge reconciliation process ensures that all patient charges are recorded, reasonable, and supported by encounter documentation. The methodology and the documentation necessary to support the charge reconciliation process at the FHCs are varied or non-existent. We found that only five of the twelve FHCs performed detailed reconciliations. Non-existent or inconsistent charge reconciliation among the FHCs may result in lost, unbilled, or incorrectly billed charges. MIHS should implement a consistent charge-entry reconciliation process.

Charge Documentation

In a number of instances, FHC staff were unable to locate encounter forms, lab requisition forms, and other supporting documentation. The encounter form is the tool used in the charge entry process that records, supports, and reports the patient service activity at the FHC. For billing purposes, the encounter form is used to describe the patient service by specific service codes. Each code corresponds to a particular medical service. When clinics cannot locate encounter form documentation, effective charge reconciliation cannot be performed and the risk for lost, unbilled or, incorrectly billed charges is increased. MIHS should ensure all documentation related to patient encounters be maintained on-site.

Billing Inconsistencies

Some encounters did not reconcile from the detailed bill to the filed claim for a variety of reasons. Billing reconciliation discrepancies were found in 3 (3.2%) of 94 accounts tested. Inconsistencies between encounter forms and bills can result in unbilled charges and payment delays. MIHS should ensure that the billing process is designed to bill patient services consistently.

Unbilled Services (FHC)

We found that 5 percent of the accounts on the patient accounting system show zero total charges. We judgmentally selected a small sample (5 accounts) to verify that the zero account patients did not receive services. One of the selected accounts represented an actual visit in which a patient received services. The charges were not entered for the services provided because the associated billing code had not yet been created and provided to the FHC. Unbilled services represent lost revenue and cash flow to MIHS. MIHS should ensure appropriate charges are supported and billed timely.

Unsupported Charges

One patient account tested was not supported by any documentation maintained at the FHC. The service was not referenced in the patient's medical record, and no forms were found to support the visit, such as test results, encounter form, or lab request form. Unsupported billings may expose MIHS to significant payor repercussions. MIHS should research and, if appropriate, refund amounts related to the unsupported account and perform appropriate reconciliations to avert future unsupported charges.

Failed Billings Report

Encounters that have errors result in a "failed bill" and are placed on a "failed bill report". The failed bill report increased in size from $9,787 as of February 20, 2001 to approximately $25,457 as of March 29, 2001. Many bills on the failed bill report are identified as "code is required". This descriptor means that the bill must be sent to Medical

Records to be coded. However, a specific coder is not assigned to the FHCs, and the failed bills do not receive immediate attention. Inattention to these bills could result in lost bills, revenue and cash flow, or additional failures due to expired time limits with respect to billing certain payers. MIHS should consider improving the process of assigning codes to claims.

Unbilled Services (CHC)

Based upon discussions with Comprehensive Healthcare Center (CHC) representatives and the Director of Business Operations for Ambulatory Care, certain billable items do not appear to have been billed due to potential misunderstandings of compliance and regulatory issues. The Director originally estimated unbilled services to be about $1,000,000. After initial inquiries into these billing issues, the Director stated that the Billing Office is researching and submitting claims for reimbursement of previously unbilled facility fees. At issue within the CHC was the possible failure to bill for certain facility fees in conjunction with services provided to patients. MIHS should provide education and policies to ensure the proper capture of facility charges.

Introduction

Background

Maricopa Integrated Health System (MIHS) is the healthcare safety net for Maricopa County citizens. The health system serves people of many races and nationalities who come from diverse cultures and speak several different languages. Many patients face major challenges, such as a lack of health insurance, complex medical problems, and difficult socioeconomic situations. MIHS is committed to giving culturally appropriate sensitive medical care and helping their patients live healthier lives.

Healthcare coverage is provided to the community through a number of health plans and programs. MIHS specializes in enabling those with or without private insurance to obtain quality healthcare. The health system also participates in a wide range of government and grant-supported programs.

MIHS currently offers four health plans to its enrollees within the county:

- **HealthSelect** - An HMO with a Primary Care Physician (PCP) network of over 200 physicians and affiliation with nine hospitals throughout the valley.
- **Maricopa Senior Select Plan** - An HMO with a Medicare+Choice contract, open to all Medicare-eligible seniors and individuals with disabilities entitled to Medicare.
- **Maricopa Health Plan** – A managed care plan that contracts with AHCCCS to give healthcare to members who choose or are assigned to Maricopa Health Plan (MHP).
- **Maricopa Long-Term Care Plan** - A managed care plan that contracts with the Arizona Long Term Care System to provide healthcare to members who choose or are assigned to the Maricopa Long Term Care Program.

Mission

MIHS' stated mission is: "To provide a full spectrum of high quality, wellness oriented healthcare in an organized, cost sensitive and customer oriented academic environment."

Purpose and Services

As a component of their mission to offer safe, cost-effective and quality healthcare to the public, MIHS provides physician services outside of the hospital setting. MIHS operates twelve Family Healthcare Centers (FHCs) located throughout Maricopa County including the McDowell Healthcare Center, a

specialty clinic for people who are HIV positive. Outpatient primary and specialty care is also offered at the Comprehensive Healthcare Center (CHC) located at the Maricopa Medical Center (MMC).

The FHCs offer physician services ranging from family medicine, gynecological, pediatric, dental, and mental health to ancillary services including radiology, pharmacy and laboratory. MIHS contracts with MedPro, a physician network, to provide physician services to patients. Patients range from those who require neonatal and pediatric attention to elderly patients requiring geriatric care. The FHCs serve to carry out MIHS' plan to offer physician services by offering care to patients in a range of healthcare specialties. The FHCs developed separate written programs and operational goals and prepare monthly operating reports.

The CHC, although mentioned as a Family Health Center, serves as a branch of MMC and often is the setting for many inpatient visits. The CHC serves as a referral center for FHC patients who are in need of specialized medical attention above what FHCs are able to offer. The subspecialties offered at the CHC include women's care, dialysis, oncology, antepartum testing, ophthalmology, ear/nose/throat, cardiology, orthopedics, and rehabilitation services. Currently, the CHC is undergoing an expansion to "allow for even greater service to our patients and our community." Additions and improvements to the center are scheduled to be completed by August 2001.

Although the FHCs service patients from a diverse payor mix, the purpose behind the clinics is to service MIHS health plan members in need of ambulatory attention. The clinics are not set up to generate referrals to MMC. The clinics exist to serve the general medical needs of the health plan members and, if possible, give sufficient medical attention in order to limit the number of referrals to the MMC or other contracted hospitals.

Plans to expand the FHCs include a larger space for the Mesa clinic and constructing or developing new sites for the Scottsdale and Seventh Avenue clinics. According to MIHS management, FHCs' growth decisions are based on plan demographics and not on profitability or geographical considerations such as proximity to MMC.

A twelve member Maricopa Hospital and Health System Board acts as an MIHS oversight body. The Board reports to the Maricopa County Board of Supervisors. MIHS has also established several committees dedicated to the quality assurance of healthcare delivery.

Business Plan

MIHS Family Health Centers FY 2002 Business Plan includes:

- Explore potential new FHC sites

- Expand service hours
- Expand specialty physician services at FHCs
- Relocate/Replace the Scottsdale and 7th Avenue FHCs
- Consider birthing center development
- Expand the Chandler FHC

Tobacco Tax Funding

MIHS receives reimbursement for some patient services through the Tobacco Tax Program. In 1995 Arizona voters passed the Tobacco Tax and Health Care Act (Proposition 200) which increased the state sales tax on tobacco products. The program funds:

- Healthcare for the medically needy, medically indigent and low income children
- Tobacco education and prevention
- Tobacco related research.

Qualifying patients receive healthcare from providers who are in turn reimbursed for services provided to the medically needy and indigent. Primary care, gynecological, pediatric and dental services are reimbursed through the Tobacco Tax Program.

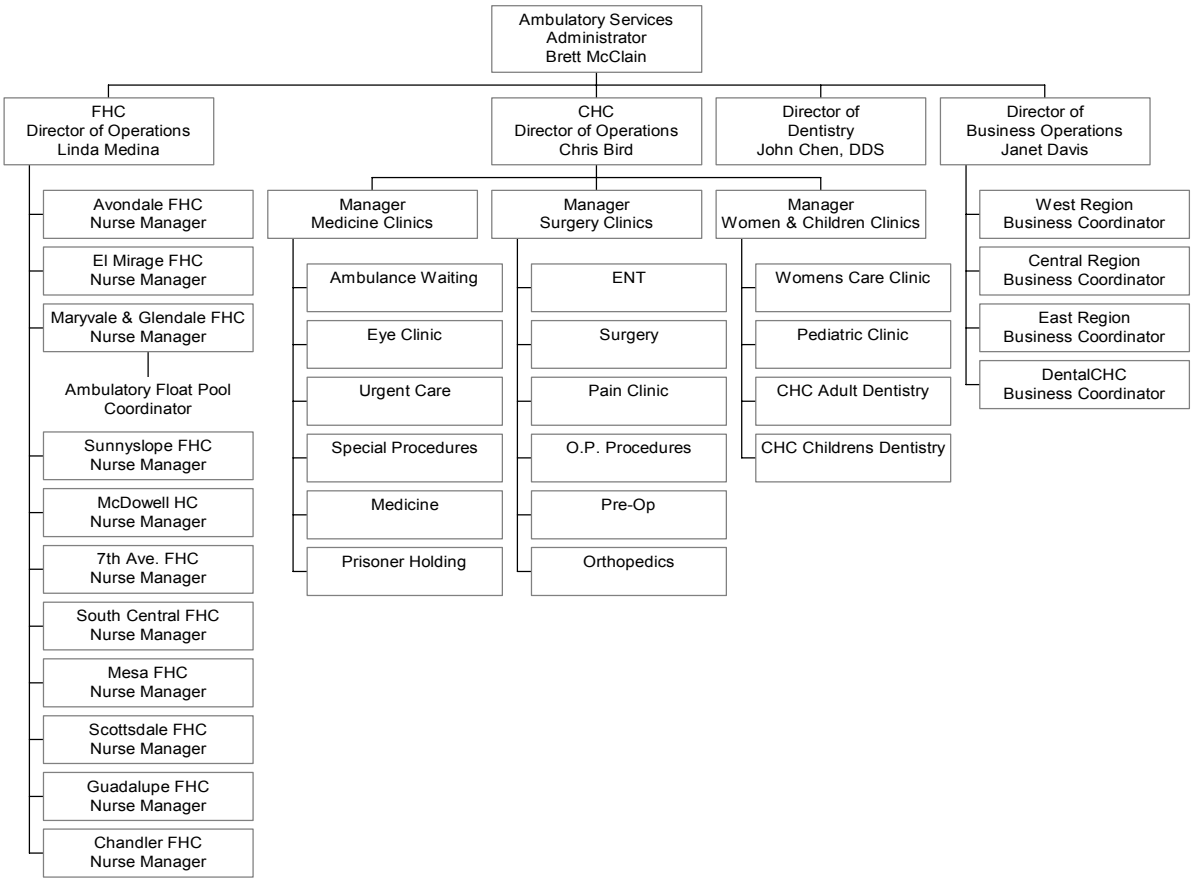
Quorum Management

The Board originally contracted with Quorum Health Resources, Inc. to provide MIHS management services for a one-year period, effective January 20, 1997. Subsequent amendments extended the contract terms to June 30, 2001 and established Quorum's eligibility to earn performance incentive payments.

Anticipating the Quorum contract expiration, the County issued a "Request For Proposal" for MIHS management services. Intensive Resource Group, LLC (IRG), a wholly owned subsidiary of Quorum, was awarded the contract. The approved IRG contract term is July 1, 1999 – June 30, 2001, plus three one-year contract renewal options. For FY 2000, the expenditure impact was a $660,000 base management fee, $500,000 for potential performance incentive awards, and approximately $1,400,000 for salaries, benefits and reimbursable expenses. Arthur Andersen, LLP, was engaged to perform a review of the incentive awards issued to IRG for the fiscal year ended June 30, 2000. (See separate report dated April 2001.)

Organizational Structure

MIHS
Ambulatory Services



Scope and Methodology

Audit objectives were to determine MIHS Family Health Centers':

- Compliance with existing laws and regulations
- Effectiveness of program operations
- Validity and reliability of data
- Safeguarding of resources.

The scope of this internal audit was limited to specific areas within MIHS Family Health Center operations:

- Charge Entry and Capture
- Charge Documentation

- Compliance with Medicare Documentation Requirements
- Patient Registration
- Current Contracts
- Charge Reconciliation.

This review was conducted by an outsourced internal audit team and was performed in accordance with Government Auditing Standards.

Potential Areas For Further Review

Due to limited internal audit resources, the items listed below were not reviewed; future testing should take into consideration the materiality of these items as they relate to the operations at the Family Health Centers:

- Medical Services Billing and Collections
- Medical Records Security, Control, and Accuracy
- A Review of the Physician Contract with MedPro
- Profitability and Viability of the FHCs
- Health Insurance Portability and Accountability Act (HIPAA)
- A Review of Medicare Modifiers
- Accounting Systems and Financial Reporting.

Issue 1 Advance Beneficiary Notices

Summary

Maricopa Integrated Health Systems (MIHS) Family Health Centers (FHC) lose the ability to bill patients for services not covered by Medicare when the FHCs do not advise patients, through Advance Beneficiary Notices (ABNs), that Medicare may not pay for specified services. Andersen sampled 79 of 187 Medicare denials for a recent nine-month period and determined that 100% of the sample did not have ABNs on file. This finding represents approximately $15,000 in denied Medicare claims that MIHS cannot bill to patients. MIHS should ensure that ABNs are provided to Medicare beneficiaries when appropriate.

HCFA Requirements

According to the Health Care Financing Administration (HCFA), an ABN must be issued each time a health care provider determines that Medicare will not cover specific services due to lack of medical necessity or reasonableness. In cases where Medicare denies payment, the health care provider will not be able to bill the patient for its services unless an ABN had been issued and an explanation was given to the patient prior to the provision of services.

Review Results

Andersen tested 79 of 187 Medicare claims denied over a recent nine-month period and found no evidence in patients' medical records to verify that ABNs had been issued. Accordingly, approximately $15,000 of patient charges incurred during the nine-month period is not billable or collectible. This situation has occurred because MIHS has not instituted effective systems for identifying, communicating, training and following up on ABN requirements.

Recommendations

MIHS should:

A. Implement formal procedures to ensure that ABNs are provided to Medicare beneficiaries when appropriate.

B. Perform training for staff and physicians to inform them of the policies and procedures with respect to ABNs and the limitation of liability requirements imposed by this requirement.

C. Review Medicare denials regularly to ensure ABNs have been provided and that beneficiaries have been properly and appropriately billed.

Issue 2 Charge Reconciliation

Summary

A charge reconciliation process ensures that all patient charges are recorded, reasonable, and supported by encounter documentation. The methodology and the documentation necessary to support the charge reconciliation process at the FHCs are varied or non-existent. We found that only five of the twelve FHCs performed detailed reconciliations. Non-existent or inconsistent charge reconciliation among the FHCs may result in lost, unbilled, or incorrectly billed charges. MIHS should implement a consistent charge-entry reconciliation process.

Control Requirements

The MIHS Business Office requires that detailed reconciliations be performed daily to ensure that all charges are reasonable and supported by encounter documentation. Moreover, FHCs are required to daily reconcile the encounter forms to patient accounting system reports (HBO Star). Reconciliations ensure that all encounters for the day have been accurately and completely entered into the HBO Star system.

Test Results

Based on Andersen's discussions with FHC charge-entry personnel and nurse managers, we learned that reconciliations from the encounter forms to the HBO Star report are inconsistently performed or, in some instances, are not performed at all. Only five of the twelve FHCs performed detailed reconciliations. Two FHCs did not perform reconciliations and five performed only cursory reconciliations. The seven FHCs that do not comply with MIHS policy constitute a 58 percent error rate. This condition may be attributed to insufficient training and oversight procedures. Accordingly, inadequate procedures may result in lost, unbilled or incorrectly billed charges.

Recommendations

MIHS should:

A. Implement a consistent charge-entry reconciliation process that includes consistent documentation. Registration personnel should ensure that all patients seen are recorded on the day sheet. Charge-entry personnel should first reconcile the encounter forms to the day sheet to ensure that all patients seen have appropriate encounter forms. A standard form should be used to perform this reconciliation.

B. Reconcile all charges entered into HBO Star to the appropriate encounter forms each day to ensure that all services provided were appropriately charged. This reconciliation should be documented, and the documentation kept on site with the related encounter forms.

Issue 3 Charge Documentation

Summary

In a number of instances, FHC staff were unable to locate encounter forms, lab requisition forms, and other supporting documentation. The encounter form, as previously mentioned, is the tool used in the charge entry process that records, supports, and reports the patient service activity at the FHC. For billing purposes, the encounter form is used to describe the patient service by specific service codes. Each code corresponds to a particular medical service. When clinics cannot locate encounter form documentation, effective charge reconciliation cannot be performed and the risk for lost, unbilled or, incorrectly billed charges is increased. MIHS should ensure all documentation related to patient encounters be maintained on-site.

MIHS Requirements

MIHS requires that all medical records, including the applicable encounter forms, be maintained on-site for two years. Additionally, a review of MIHS laboratory procedures by the College of American Pathologists (CAP) determined that laboratory requisitions including physician's instructions should also be maintained for two years. Based on these requirements, the missing documents identified represent exceptions that may result in lost, unbilled, or incorrectly billed charges.

Medical Records Condition

Supporting documents for 35 of 94 accounts tested related to the charge entry process were either misplaced or destroyed. This represents a 37.2 percent error rate that may be attributed to inadequate training and oversight procedures. The missing documents represent exceptions that may result in lost, unbilled or incorrectly billed charges.

Recommendation

MIHS should ensure all documentation related to patient encounters be maintained on-site for a period of two years, which includes the encounter form and support for any additional charges.

Issue 4 Billing Inconsistencies

Summary

Some encounters did not reconcile from the detailed bill to the filed claim for a variety of reasons. Billing reconciliation discrepancies were found in 3 (3.2%) of 94 accounts tested. Inconsistencies between encounter forms and bills can result in unbilled charges and payment delays. MIHS should ensure that the billing process is designed to bill patient services consistently.

Billing Requirements

Billing for services is a critical business process, central to the successful completion of the FHCs mission. A well-designed billing process results in improved cash flow, a decrease in denied claims and less exposure to regulatory issues. Requirements for an effective billing system must include implemented controls to ensure accuracy, completeness, consistency, and timeliness.

Test Results

Andersen found billing reconciliation discrepancies in 3 of the 94 accounts tested. One of these discrepancies represented an instance where a patient, whose primary insurance was a capitated plan, had one immunization charge billed as both a facility and a professional bill. Although this duplicate billing did not result in an incorrect reimbursement, it does represent a system deficiency in the insurance setup and the registration process associated with this type of plan. Combined, the three exceptions identified represent an error rate of 3.2 percent.

Inconsistencies between encounter forms and bills can result in unbilled charges and delays in payment for services provided. These inconsistencies may occur because systems for identifying, communicating, training, and following up on billing processing are not as effective.

Recommendations

MIHS should:

A. Ensure that the billing process is designed to bill patient services consistently. In the event of a billing exception, sufficient documentation should be attached to the patient's account to ensure the exception was properly resolved.

B. Ensure that all physicians have an appropriate provider number assigned to them in order to prevent delays in billing and reimbursement for services provided.

Issue 5 Unbilled Charges

Summary

We found that 5 percent of the accounts on the patient accounting system show zero total charges. We judgmentally selected a small sample (5 accounts) to verify that the zero account patients did not receive services. One of the selected accounts represented an actual visit in which a patient received services. The charges were not entered for the services provided because the associated billing code had not yet been created and provided to the FHC. Unbilled services represent lost revenue and cash flow to MIHS. MIHS should ensure appropriate charges are supported and billed timely.

Charge Capture Requirements

To maximize the financial results of the FHCs, all services need to be captured and billed in a timely manner.

Charges Report

A significant number of accounts were created in HBO Star with zero total charges. An account with zero total charges represents a patient visit where services have not been provided to the patient. Andersen judgmentally selected a small sample of these accounts to verify the patients did not receive services. One of the accounts selected from the test sample was found to represent an actual visit where a patient received services.

Of the total population of 143,988 accounts created related to the FHCs, 7,151 accounts (5% of the population) were accounts with zero total charges. Andersen selected five accounts judgmentally and found one account where FHC services were provided. Although the patient visited and received FHC services, the proper code to capture this charge was not set up and available for use by the FHC; therefore, services were not billed. Because the billing code had not been set up, FHC personnel were instructed by Billing Office personnel not to enter the charges. Unbilled services represent lost revenue and cash flow to MIHS.

Recommendations

MIHS should:

A. Ensure that all necessary procedure charge codes are properly set up and included in the FHC encounter form.

B. Initiate review and reconciliation procedures to monitor the level of unbilled accounts to ensure appropriate changes are supported and billed timely.

Issue 6 Unsupported Charges

Summary

One patient account tested was not supported by any documentation maintained at the FHC. The service was not referenced in the patient's medical record, and no forms were found to support the visit, such as test results, encounter form, or lab request form. Unsupported billings may expose MIHS to significant payor repercussions. MIHS should research and, if appropriate, refund amounts related to the unsupported account and perform appropriate reconciliations to avert future unsupported charges.

Documentation Requirements

To adequately support charges incurred, the FHCs must maintain documentation on site for a period of at least two years, including the encounter form, laboratory test request form, and supply/pharmaceutical requisition forms, before sending this documentation to storage.

Review Results

A patient account selected as part of the auditors' sample with total charges of $345 was not supported by appropriate documentation. The documentation to support these services was not referenced in the patient's medical record, and no forms were found to support the visit. The supporting documentation should have included the encounter form, lab request form, and lab test results. The charges on this account represent 2 percent of the total sample population of $16,533.

Because the services provided were not referenced in the patient's medical record, the bill for this account is completely unsupported and exposes MIHS to potential payor repercussions. This exception is an example of control weaknesses identified in the previous issues.

Recommendations

MIHS should:

A. Research and, if appropriate, refund amounts related to the unsupported account to the proper payor (AHCCCS).

B. Perform appropriate charge entry reconciliation, and maintain documentation supporting charges entered to avert future unsupported charges.

C. Perform periodic quality control reviews to ensure compliance with industry documentation standards.

Issue 7 Failed Billings Report

Summary

Encounters that have errors result in a "failed bill" and are placed on a "failed bill report". The failed bill report increased in size from $9,787 as of February 20, 2001 to approximately $25,457 as of March 29, 2001. Many bills on the failed bill report are identified as "code is required". This descriptor means that the bill must be sent to Medical Records to be coded. However, a specific coder is not assigned to the FHCs, and the failed bills do not receive immediate attention. Inattention to these bills could result in lost bills, revenue and cash flow, or additional failures due to expired time limits with respect to billing certain payors. MIHS should consider improving the process of assigning codes to claims.

Billing Requirement

To ensure proper reimbursement for all services provided to patients, errors should be minimized and immediate attention given to billings with errors.

Test Results

As of March 29, 2001, the "failed bill report" items totaled $25,457, with $22,991 being directly attributable to medical claims that require the necessary codes for billing. Failed billings related to coding issues represent 305 of the 374 accounts on the report. Inattention to these bills could result in lost bills, revenue and cash flow due to expired time limits with respect to billing certain payors. Because no specific coder is assigned to the FHCs, failed bills may not receive immediate attention. See the Appendix for a graph showing relative dollar values of other failed billing sources.

Recommendation

MIHS should consider the benefits of assigning a coder, or at least designate one-half of a coder's time, specifically for the FHCs to help facilitate the process of assigning codes to claims that require attention from the Medical Records Department.

Issue 8 Unbilled Services (CHC)

Summary

Based upon discussions with Comprehensive Healthcare Center (CHC) representatives and the Director of Business Operations for Ambulatory Care, certain billable items do not appear to have been billed due to potential misunderstandings of compliance and regulatory issues. The Director originally estimated unbilled services to be about $1,000,000. After initial inquiries into these billing issues, the Director stated that the Billing Office is researching and submitting claims for reimbursement of previously unbilled facility fees. At issue within the CHC was the possible failure to bill for certain facility fees in conjunction with services provided to patients. MIHS should provide education and policies to ensure the proper capture of facility charges.

Billing Requirements

Medical billings contain two components; a facility fee, which is what the hospital/clinic provides (i.e., x-ray, surgical procedures, etc.) and the professional component, which is what the physician bills for services in conjunction with the facility fee (i.e., x-ray interpretation, consultation, etc.). Generally, Medicare patients must be final billed for both of these components within twelve months in order for MIHS to receive reimbursement.

Review Results

Certain billable items do not appear to have been billed. These billable items relate to Medicare patients and for services provided within the previous twelve months. The Director of Business Operations for Ambulatory Care estimates unbilled services to be about one million dollars. These services are related to administration fees for immunizations, injections, and antibiotics, as well as certain services performed at the eye clinic, and physicals performed and not billed for fear of violating the Medicare "72- Hour Rule."

After the initial inquiry into the billing issues, the Director of Business Operations, in cooperation with MMC, developed a new procedure to appropriately capture all facility charges associated with the services provided. The Director stated that the MIHS Billing Office is researching and submitting claims for reimbursement of previously unbilled facility fees. The Director was unable to estimate either the final actual dollar value of the claims previously unbilled or the value of the billed/re-billed claims to date. Additionally, according to the Director, lost claims (those claims not allowed to be billed due to time limitations) cannot be estimated either.

Billable items apparently were not billed due to misunderstandings of compliance and regulatory issues, and the fear of violating the 72-Hour Rule. Training and documentation related to the types of services to be billed, and the timeline for properly billing, appear to be inadequate.

Recommendations

MIHS should:

A. Provide continuing education to physicians on the proper capture of facility charges, in particular, new services or services that have historically not been billed.

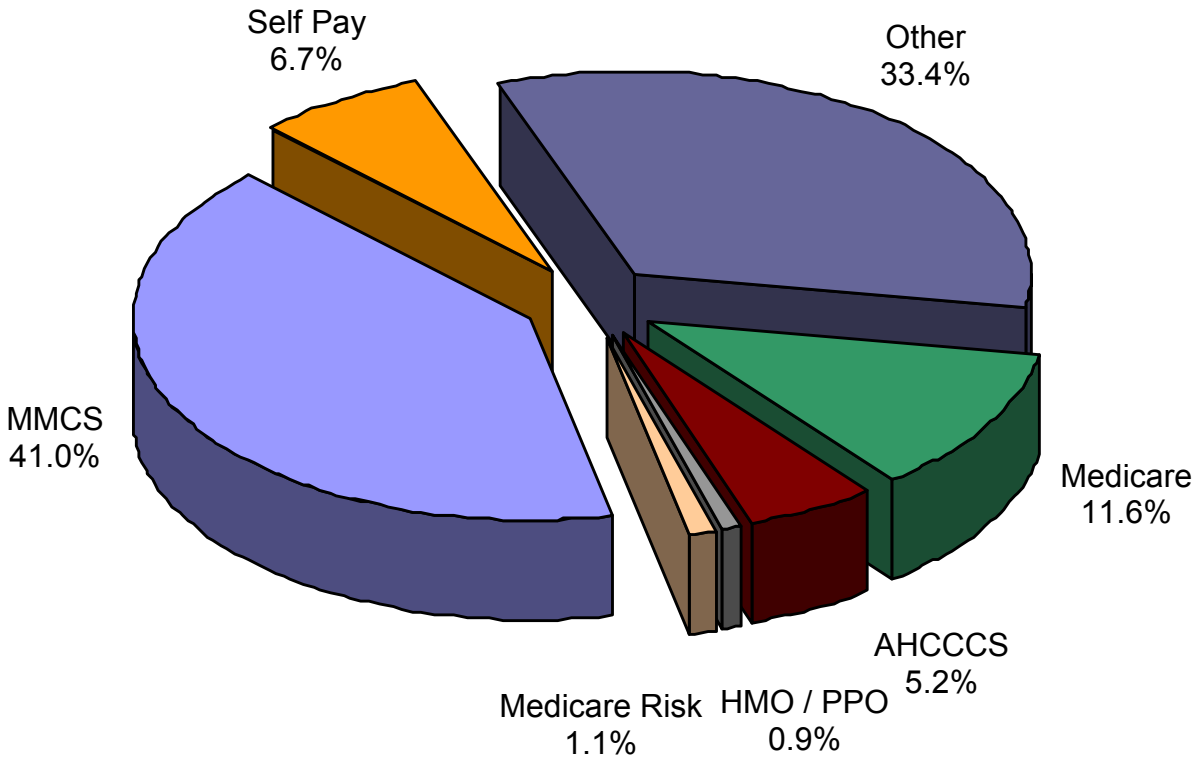
B. Consider creating policies and procedures for the regular maintenance and updating of the acuity encounter sheets.

DEPARTMENT RESPONSE

Appendix

Payor Mix

Family Healthcare Clinics



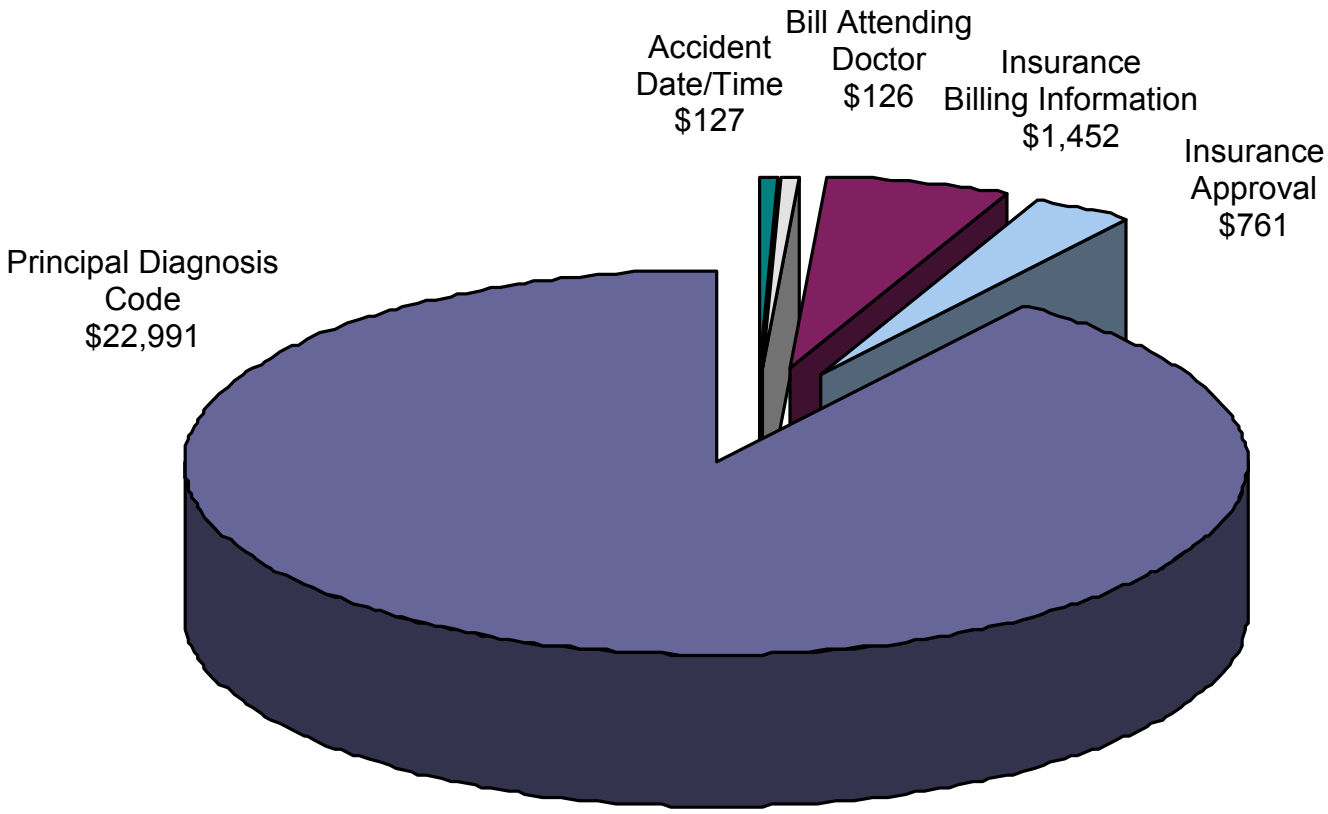
Based on Monthly Operating FHC Reports by Clinic YTD FY2001

As of February 14, 2001

MIHS Failed Billings

by Failure Code

Failure Code Identifies Missing Information



Based on Failed Billing Report
As of March 29, 2001
Total $25,457

Reason / Volume for Failed Billings:	
Accident Date/Time Required	2
Attending Doctor Required	9
Insurance Billing Information Required	35
Insurance Approval Required	23
Principal Diagnosis Code Required	305

Total Reasons for Failed Billing 374

NOTE: A single bill may be failed for more than one reason